_____
Consumer Name

DEPARTMENT OF HUMAN SERVICES
Division of Developmental Disabilities
HOME AND COMMUNITY-BASED SERVICES WAIVER
CHOICE AND RIGHTS

I have been told of the services available to me from the Home and Community-Based Services Waiver, after this referred to as "HCBS". I know that the HCBS program offers services to people with intellectual/developmental disabilities. I have also been given a list of all of the HCBS providers in South Dakota.

I understand that I have the right to choose the HCBS program or the institutional services available in the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). I want to receive services from the HCBS program.

If a HCBS provider decides to terminate or reduce my services, I know that the provider must provide me with notice of its intention to terminate or reduce my services prior to the termination or reduction. I understand that I may appeal the termination or reduction decision to the Division of Developmental Disabilities (Below is contact information for the Division). When a termination or reduction is being appealed, I shall continue receiving services in their entirety from the provider until a decision is reached after a hearing pursuant to South Dakota Codified Law chapter 1-26.

I know that I can call or write a program specialist at the Division of Developmental Disabilities at any time to talk about any complaints, concerns or questions I may have about HCBS, a provider and/or decisions made by the Division about me. I also know that if I have any questions and comments about the above information, I can contact a program specialist at:

Division of Developmental Disabilities
c/o 500 East Capitol
Pierre, SD 57501.
Toll Free in South Dakota: 1-800-265-9684 or (605) 773-3438.

I understand that the Department of Social Services and the Department of Human Services prefer to work out differences through talking and compromise among all interested parties prior to putting into action appeal and hearing processes.

Participant and/or Legal Representative Signature Date

Provider's Admissions Coordinator or Case Manager Signature Date

cc: Division of Developmental Disabilities
Participant and/or Legal Representative

_____
Consumer Name

DEPARTMENT OF SOCIAL SERVICES
HOME AND COMMUNITY-BASED SERVICES WAIVER
FAIR HEARINGS

I have been told that I can ask for a fair hearing if I am not given the choice of Home and Community-Based Services as an alternative to institutional care. I understand that I can ask for a fair hearing if I am denied a Home and Community-Based Waiver Service or if I am denied the provider of my choice.

I understand that I must contact any Department of Social Services' office and request a fair hearing. I have been told that a request for a fair hearing may be made orally or in writing with any Department of Social Services office or to the Department of Social Services' Administrative Hearings Office at (605) 773-6851. I shall direct my request to the social worker or the caseworker or to the Administrative Hearings Office at:

Department of Social Services:
Kneip Building
700 Governors Drive
Pierre, South Dakota 57501

I understand that I can have a lawyer represent me at the fair hearing but his or her costs will not be paid by the Department of Social Services.

I have been told that I have the right to receive fair treatment regardless of my race, color, national origin, religious creed, sex, disability or age. If I feel that any of my rights have been violated or not honored in any way, I can ask for a fair hearing.

I have been told of my right to privacy and that the information I have given concerning my request for Home and Community-Based Services will only be used for determining eligibility.

I have received Department of Social Services material that gives me more information regarding the fair hearing process.

I understand that the Department of Social Services and the Department of Human Services prefer to work out differences through talking and compromise among all interested parties prior to putting into action appeal and hearing processes.

Participant and/or Legal Representative Signature Date

Provider's Admissions Coordinator or Case Manager Signature Date

cc: Division of Developmental Disabilities
Participant and/or Legal Representative